



MONTANA STATE PRISON HEALTH SERVICES OPERATIONAL PROCEDURE

Procedure No.: MSP HS G-03.0	Subject: Infirmary Care
Reference: NCCHC Standard P-G-03,2014	Page 1 of 5 and no attachments
Effective Date: November 1, 2010	Revised June 1, 2017
Signature / Title: /s/ Cindy Hiner / Health Services Manager	
Signature / Title: /s/ Tristan Kohut, D.O. / Medical Director	

I. Purpose:

To house inmates who do not require general acute care level of services, but are in need of skilled nursing care to manage serious medical needs which cannot be managed safely in an outpatient setting. To provide inmates with inpatient services consistent with their needs that is necessary to protect life, prevent significant illness or disability, or to alleviate significant pain.

Infirmary services consist of isolation, observation, first-aid, preoperative preps, postoperative care, psychiatric care and/or restraint, suicide watch, short or long term nursing, treatment of minor illnesses, sheltered living, convalescence, and end-of-life care.

II. Definitions:

Infirmary Care - care provided to patients with an illness or diagnosis that requires daily monitoring, medication and/or therapy, or assistance with activities of daily living at a level needing skilled nursing intervention.

III. Procedures:

A Staffing

1. A physician on call (POC) is available 24 hours a day, seven days a week. When health care assistance from a POC is required the on duty Registered Nurse (RN) / Licensed Practical Nurse (LPN) will contact the POC.
2. RN coverage will be a minimum of 12 hours per day, seven days a week.
3. A designated call RN will be assigned at all times when an RN is not on site at MSP
4. Determining the number of sufficient and appropriate qualified health care professionals in the infirmary is based on the number of patients, the severity of their illnesses, and the level of care required for each.

B. Criteria for Infirmary Placement

Infirmary placement includes one of three categories:

1. Medical Observation - this is used to determine a diagnosis, to collect biological samples, monitor an inmate's food intake prior to an invasive procedure, pre-op care, and behavioral observation or for other reasons. Observation status is defined as placement in the Infirmary for less than 24 hours and may be performed by a qualified health care professional other than a physician.
2. Acute Care - an inmate may be placed in an infirmary bed to diagnosis or treat an illness. Services may include postoperative care, first aid, isolation, treatment of minor illness, short term nursing care e.g. administration of IV medications, and special procedures. Acute care status may also include individuals admitted for mental health disorders, including suicide observation, psychiatric care, and/or restraint. Acute care patients are admitted and discharged only by a physician order, or by another clinician where permitted by virtue of his or her credentials and scope of practice.

Procedure No. MSP HS G-03.0	Subject: Infirmary Care
Effective Date: November 1, 2010	p.2 of 5

3. Chronic Medical Housing/Sheltered Housing - inmates may be placed in the infirmary for “medical housing.” This is needed for inmates with chronic medical problems inappropriate for housing in a typical general population bed. Examples include inmates who are in need of sheltered living, convalescence, or long term nursing care.
4. Inmates whose level of care or medical needs include any of the following will not be housed in the Infirmary, and will be transferred to a general acute care hospital:
 - cardiac monitoring
 - chest tube
 - total parenteral nutrition
 - hyperbolic oxygen
 - major surgery
 - intensive care
 - ventilator care
 - central pressure monitoring
 - transplant procedures

This list is not exhaustive; other medical conditions may require transfer from the Infirmary, as specified by a physician.

C. General Instructions

1. Only a member of the medical staff within the scope of his/her license may diagnose illness or prescribe treatment.
2. The inmate’s condition and provisional diagnosis will be written on the Admissions Sheet and Progress Notes of the Medical Record within 24 hours of the admission by the admitting member of the health care staff.
3. Patients are always within sight or hearing of a qualified health care professional.
4. Within 24 hours after admission, every inmate will have an evaluation for immediate care planning. Health care staff will be held responsible for the content and completeness of the Medical Record. This will include appropriate history and physical, assessment, and treatment of each inmate who is admitted.
5. Health care staff will ensure a complete written or dictated history and physical examination is placed in the Medical Record within 72 hours, unless it was completed within five days prior to admission.
6. Inmates will be admitted, discharged, or transferred only by a written order by the attending physician or his/her physician designee. Should an inmate refuse medical treatment against the advice of the attending physician, a notation of the incident will be made in the Progress Notes and a Refusal of Medical Treatment sheet will be signed, if possible, and placed in the Medical Record. Although an inmate may refuse all treatment the inmate may not refuse the location in which they are housed and may be required to be housed in the Infirmary at the Medical staff’s discretion.
7. Short-stay admission: A written or dictated history and physical examination will be performed by a physician on each inmate returned to the Infirmary for observation following discharge from any health care facility. The history and physical examination may be abbreviated but must include all pertinent physical finding summary of relevant history (not “see prior chart”) and all current medications.
8. Section G or Behavioral Management Plan designated inmates who require medical care while serving either one of these security designations will not complete their BMP or Section G while housed in the main infirmary. When medical care has been rendered and

Procedure No. MSP HS G-03.0	Subject: Infirmary Care
Effective Date: November 1, 2010	p.3 of 5

- patient is deemed stable for discharge to housing unit, then the Section G or BMP will resume. The main infirmary is not a housing unit and any placement whether by security, mental health, or medical staff will still require physician notification and admit orders.
9. At the time of discharge, the attending physician or his/her designee will see that a final diagnosis and discharge summary is written or dictated prior to or at discharge on all medical records of the inmates.
 10. The discharge summary will include the final diagnosis, clinical resume, and discharge orders. The final diagnosis will be recorded in full without the use of symbols.
 11. An admission note will be completed, on the Progress Note Sheet, by the admitting physician on the day of admission or the first day the inmate is seen by the physician.
 12. Admission orders will contain: admission diagnosis; diet; condition; level of activity; orders for vital signs including frequency; lab and x-ray orders; code status; and medications with stop dates, where appropriate.
 13. A Progress Note completed by the attending physician will be required at least every day (excluding weekends) or more often as the inmate's condition requires. Nursing staff will record events that may require particular attention by the physician in the Progress Note in addition to the Assessment Flow sheet on a daily basis, when appropriate.
 14. Discharge orders will be written by the attending physician or his/her designee, and will include discharge diagnosis, medications, treatment, aftercare instructions and follow up appointments.
 15. Verbal orders given over the telephone will be signed and confirmed by the licensed nurse to whom the order was given with the name of the physician. All verbal orders will be signed by the prescriber within 48 hours, excluding weekends and holidays.
 16. All inpatient orders for medications will specify the length of time they are in effect and will not exceed 30 days.
 17. Inmates admitted to the Infirmary for dental and mental health care will be given the same basic medical appraisal as those inmates admitted for other services. Inmates admitted for dental and mental health care are a dual responsibility of the non-physician member and a physician member of the active medical staff.
 - a. Dentist or Psychiatrist (non-physician responsibilities):
 - A detailed dental/mental health history justifying admission.
 - Detailed description of the examination and diagnosis.
 - An operative report describing the findings and technique, where appropriate.
 - Progress notes pertinent to the condition.
 - Clinical resume.
 - b. Admitting Physician Responsibilities:
 - Medical history pertinent to the general health.
 - A physical examination to determine the inmate's condition.
 - Supervision of the inmate's health care while in the Infirmary.
 - Discharge summaries.
 18. When an inmate is transferred to an outside health care facility, the transfer summary will include the following: treatment course; dietary requirements; allergies; emergency medical services record; history and physical examination; adequate documentation of the inmate's present status entered by the transfer physician including lab, x-ray, and current medication. A copy of the transfer summary must accompany the inmate.

Procedure No. MSP HS G-03.0	Subject: Infirmary Care
Effective Date: November 1, 2010	p.4 of 5

19. Unless released by a court, an inmate will be released from the Infirmary only on a written order of the attending physician or his/her designee. At the time of the release, the attending physician will determine that the record is complete, state the final diagnosis, and sign the discharge summary.
20. The discharge summary will provide the provisional diagnosis, the primary and secondary diagnoses, clinical resume. The discharge summary should be concise and will briefly recapitulate the significant findings and events of the inpatient stay, including prescribed medications, aftercare plans, and condition at the time of discharge. In the event of an inmate's death, a summations statement of the circumstances leading to the death will be added to the discharge summary.
21. The Inpatient Medical Record will be used to document all inpatient medications ordered by a physician.
22. The Nursing Admission Initial Assessment narrative will commence at the time of admission and will be completed by nursing staff. The Assessment Record will be used for every 24 hour period and will reflect nursing care performed at 12 hour intervals. On each watch, the nurse responsible for the care of the inmate will complete a systems assessment; document the time of the assessment, and will sign the assessment form. Activity, physical care, elimination equipment, and teaching status will also be documented.
23. The Daily Nursing Assessment will contain a head-to-toe assessment which is to be conducted at least each shift. If an abnormality is noted a description of the abnormality, action taken (if necessary) and the inmate's response to the action taken is noted in the narrative nurses notes. The Graphic Record is included in the daily nursing assessment and the documentation of blood glucose checks, diet and percentage eaten, vital signs, intake and output, height, and weight will be included. Weight will be documented for all inmates on admission and as the inmate's conditions warrants but no less than weekly. Where appropriate, the nurse responsible for charting on the inpatient record will be responsible for totaling the inmate's intake and output. The Daily Nursing Assessment and Graphic Record will be used for every inmate admitted to the Infirmary.
24. Nursing assessment of decubitus ulcers will be performed at the first sign of skin breakdown on an inmate and followed by assessments every 12 hours thereafter.
25. Inmates will be afforded a shower at least three times per week unless otherwise indicated by a physician's order.
26. All inmates returning from medical facilities for admission will be brought to the Infirmary.
 - All paperwork and records will be obtained at this time.
 - The inmate's vital signs and assessment will be obtained and documented.
 - The physician will be contacted and given a report on the status of the inmate. The physician will make the determination for the placements.
 - If the inmate is released to the general population, follow-up instructions for care will be given to the inmate and housing unit staff.
27. When an inmate is discharged from the Infirmary by written, verbal or telephone physician's order, an inmate discharge form will be completed by the physician or RN on duty at the time of the discharge. The form will be completed as follows:
 - Date of discharge
 - Full name and AO number

Procedure No. MSP HS G-03.0	Subject: Infirmary Care
Effective Date: November 1, 2010	p.5 of 5

- Special Procedures - document any special procedures that the inmate needs to continue after discharge such as: 1) monitoring vital signs, 2) checking wound(s) for bleeding, or 3) reporting chills or fever after surgery. Also, any equipment needed will be noted.
 - Medications - the discharging physician will order any discharge medications, specifying the medication name, dose, frequency, and/or length of administration. If the discharging physician is unable to sign these discharge instructions, as in the case of a telephone order or after hour discharge, the RN will sign under the physician's signature, indicating that the discharge medication was a telephone order. The physician will sign the order within 48 hours.
 - Activity - as ordered by the physician such as: 1) no lifting, 2) no running, or 3) normal activity.
 - Diet - as ordered by the physician. Nursing staff will instruct the inmate on any dietary restrictions and request a dietitian's consultations as needed.
 - Follow-up - document the timeframes, if applicable, of any follow-up appointments.
 - Special Treatments - document any follow-up treatments such as: 1) dressing changes and 2) wound checks.
 - Medical Staff Signatures - physician signature, with date and time will indicate that the instructions are completed. A physician or an RN may sign as long as discharge instructions are concurrent with a written discharge or verbal order from the physician.
28. The RN Discharge Instruction Sheet documentation will include but is not limited to inmate education regarding a specific health problem, medication, or follow-up care appointment.
29. Infirmary admissions, discharges and continued inpatient stays will be monitored for utilization appropriateness and quality of care.
30. Infirmary admissions, discharges, average daily census, and average length of stay will be tabulated on a monthly statistical report submitted to the Health Service Division Administration.

D. Responsibilities:

1. The Health Authority will be a licensed physician. He/she will arrange for all levels of health care and is responsible for the daily administration and clinical management of the MSP Infirmary.
2. The facility, in coordination with the Warden, Security Major, and health care personal will be responsible for ensuring that security is maintained in the Infirmary.
3. All staff will be responsible for adherence to these procedures.
4. MSP medical services is licensed by the State of Montana Department of Public Health and Human Services as an infirmory, pursuant to the provisions of Montana Code Annotated; Title 50; Chapter5; part 1 and part 2.

IV. Closing

Questions concerning this operational procedure will be directed to the Health Services Manager.

V. Attachments: None